DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

155066 | (X2) MULTIPLE CONSTRUCTION
A. BUILDING _____

B. WING _____ | (X3) DATE SURVEY COMPLETED

R-C

12/11/2014 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER

EDGEWATER WOODS | STREET ADDRESS, CITY, STATE, ZIP CODE

1809 N MADISON AVE

ANDERSON, IN 46011 |
|---|---|

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS

 Paper compliance to the investigation of complaint IN00158074 completed on 10/27/14.

Complaint IN00158074 - Corrected

Review Date: December 11, 2014

Facility Number: 000026
Provider Number: 155066
AIM Number: 100274820

Surveyor: Debora Barth, RN

Edgewater Woods was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1, in regard to the paper compliance review to the complaint investigation. | {F 000} | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE   TITLE   (X6) DATE